



June 13, 2012

*Physical Therapy
 Business Alliance*

Position Statement on Alternative Payment System

The American Physical Therapy Association has recently proposed adoption of an Alternative Payment System (APS) that bases payment on patient severity in lieu of the current fee-for-service system based predominantly on the use of Current Procedural Terminology (CPT) codes. The Physical Therapy Business Alliance (PTBA) agrees with the APTA that payment reform is necessary, and we are not inherently opposed to the APS as an incremental step toward payment reform. However, the APS in its current form disproportionately emphasizes administrative and regulatory requirements (ie, documentation, compliance, etc.) at the expense of the most critical elements of the clinical encounter, which is incentivizing quality clinical outcomes and patient satisfaction. The APS also fails to address the fundamental problem of the current payment system, which is a lack of consideration for the value that physical therapy services contribute to the health care system. Any alternative system has to address and start with the economics of its impact on both the provider and payer.

The purpose of this position statement is three-fold:

- Characterize the current payment system and provide historical context for the declining payment trend for physical therapy services
- Establish the case for physical therapy services as a major contributor of value to the health care system, despite payment trends to the contrary
- Provide a construct for re-framing payment for physical therapy services based on the relative value contribution of physical therapy services and the implications of quality care on downstream health care utilization and costs.

Current Payment Model for Physical Therapy

Payment for physical therapy services is largely based on the Resource-Based Relative Value Scale (RBRVS), which assigns procedures performed by a physical therapist a relative value adjusted by geographic region. Specifically, the price for a given procedure is determined based on three factors: 1) work required (52%), 2) practice expense (44%), and 3) malpractice expense (4%). This value is then multiplied by a fixed conversion factor, which changes annually, to determine the amount of payment. Below is a brief explanation of the RBRVS payment methodology for physical therapy services over the last 20 years:

Year	Medicare Conversion Factor (CF)	RVU for 97110	1 unit (15 min)	4 units (1 visit) Actual	Adjusted for Inflation (2012 CPI)	% Decline
1992	\$31.00	.73	\$22.63	\$90.52	\$148.95	N/A
2002	\$36.19	.76	\$27.50	\$110.02	\$141.00	5.2%
2012	\$34.03	.87	\$29.61	\$112.50 (MPPR)	\$112.50	32.0%

In other words, adjusted for simple inflation, a 4 unit visit in 1992 generated \$148.45 per visit; in 2002 generated \$140.71 per visit; and in 2012 generated only \$112.50, representing a 32% decline in payment for physical therapy services over the last 20 years. In fact, the actual reduction is likely closer to 40% or more when you account for

BOARD OF DIRECTORS

- Carl DeRosa , Chair*
- James Glinn, Jr., Vice-Chair*
- Jennifer M. Gamboa , Secretary*
- Michael Weinper , Treasurer*
- Laurence N. Benz*
- John Childs*
- Paul Gaspar*
- Jeffrey W. Hathaway*
- Richard W. Shutes*



Physical Therapy
Business Alliance

BOARD OF DIRECTORS

Carl DeRosa , Chair
James Glinn, Jr., Vice-Chair
Jennifer M. Gamboa , Secretary
Michael Weinper , Treasurer
Laurence N. Benz
John Childs
Paul Gaspar
Jeffrey W. Hathaway
Richard W. Shutes

the impact of group therapy billings and the Multiple Procedure Payment Reduction (MPPR). Earning capacity is in part a proxy of a profession's relative value within the health care system. Despite the rapid increases in earning capacity among many specialty health care professions, the earning capacity of physical therapists has clearly regressed over the previous 20 years, despite many well intended advocacy efforts to reverse this trend.

One of the fundamental problems with RBRVS is that it determines payment based on the amount of effort expended, with no regard for whether that effort produces a favorable outcome. Under RBRVS, there is no consideration of the medical value to the patient for a given service nor is there any incentive to minimize costs. As a result, incentives are heavily misaligned and skewed towards the overuse of complex and therefore costly procedures as opposed to encouraging the use of effective procedures, some of which may be low cost to deliver. The misaligned incentives in our current payment system are perhaps best illustrated by the number of spinal fusions currently performed at U.S. hospitals, which has doubled to 413,000 between 2002 and 2008, generating \$34 billion in charges according to the federal Healthcare Cost and Utilization Project. Although such exorbitant fees handsomely reward spine surgeons with the highest levels of compensation in health care, many of these and other surgeries are unnecessary. Nevertheless, this fact has received scant attention in the debate over U.S. health care costs, which rose 6 percent last year to \$2.47 trillion, representing 17% of our Gross Domestic Product (GDP).⁴ It is estimated that unnecessary surgeries cost at least \$150 billion a year, a portion of which could be offset by access to early, cost effective physical therapy services.

Since services rendered by a specialist generally require more effort and specialized training, and therefore paid more according to their relative value, RBRVS has contributed to the lack of primary care physicians (PCPs) and other low cost providers such as physical therapists by incentivizing physicians to specialize rather than becoming a PCP or physical therapist. For example, as a "mid-level" provider under Medicare, the current payment model invokes a virtual salary cap for physical therapists of ~\$60,000 per year, the analysis of which can be provided upon request. Although our relative value has declined, physical therapists have an increasingly prominent role in health care due to the rapid expansion in the science of rehabilitation and their demonstrated expertise. Physical therapy education requirements (and the associated debt burden of physical therapy graduates) have correspondingly increased by ~30% due to the transition to the entry level doctoral degree. Similar to the shortage in PCPs, the paradoxical decline in relative value according to the current payment system in an environment of increased educational requirements and expertise poses significant challenges for recruiting enough physical therapists to meet the exponential increase in demand for our services due to the rapidly aging population in the U.S.

Complicating matters, the RBRVS system is mandated by the Centers for Medicare and Medicaid Services (CMS), yet the American Medical Association (AMA) maintains that their copyright of the CPT codes allows them to charge a license fee to anyone who wishes to associate RVU values with CPT codes. The AMA receives approximately \$70



Physical Therapy
Business Alliance

BOARD OF DIRECTORS

Carl DeRosa , Chair
James Glinn, Jr., Vice-Chair
Jennifer M. Gamboa , Secretary
Michael Weinper , Treasurer
Laurence N. Benz
John Childs
Paul Gaspar
Jeffrey W. Hathaway
Richard W. Shutes

million annually from these fees, representing a formidable conflict of interest when it comes to making necessary payment reforms.

Physical Therapy Services in a Value-based Payment Model

Despite the presumed “science” of CPT and RBRVS, health care costs continue to rise at alarming rates, particularly for many common musculoskeletal conditions managed by physical therapists such as low back pain (LBP). Compounding the problems of CPT/RBRVS is the often hidden costs of capricious Medicare rules and regulations (ie, one-on-one definition, 8-minute rule, explicit provider list, etc), which unnecessarily interfere with our ability to practice autonomously or efficiently.

Despite regressive trends and asymmetrical market forces that have commoditized physical therapy payment to an unsustainably low level, the true value of receiving care from a physical therapist has risen sharply during this same period. For example, Gellhorn et al¹ recently evaluated the relationship between early physical therapy for acute LBP and subsequent use of lumbosacral injections, lumbar surgery, and frequent physician office visits for LBP in a sample of CMS physician outpatient billing claims. There was a substantially lower risk of subsequent health care utilization among patients who received physical therapy soon after an episode of acute LBP compared to those who received physical therapy at later times. After adjusting for age, gender, diagnosis, treating physician specialty, and comorbidity, the odds of undergoing surgery among patients who received early physical therapy (<4 weeks) compared to those receiving late physical therapy (>3 months) was 0.38 (95% confidence interval [CI], 0.36-0.41). The odds of receiving a lumbosacral injection in the group receiving early physical therapy was 0.46 (95% CI, 0.44-0.49), and the odds ratio for frequent physician office usage in the group receiving early physical therapy phase was 0.47 (95% CI, 0.44-0.50) compared to late physical therapy.¹

Fritz and colleagues² also recently demonstrated among 32,070 patients from employer-sponsored health plans that that early physical therapy (within 14 days of diagnosis) for the treatment of newly diagnosed LBP is associated with a reduced risk of subsequent health care utilization and associated costs compared with delayed physical therapy. Specifically, compared with delayed physical therapy, patients with LBP who received early physical therapy had a reduced likelihood of receiving advanced imaging (odds ratio [OR], 0.34) and were less likely to require additional physician visits (OR, 0.26), surgery (OR, 0.45), injections (OR, 0.42), and opioid medications (OR, 0.78). Overall, early physical therapy resulted in \$2,736.23 less in total medical costs for LBP per case. These findings suggest that delaying the initiation of physical therapy may increase risk for additional health care consumption and costs. Despite these findings, the utilization of physical therapy was only 7%, suggesting that additional investments in cost-effective physical therapy services is likely a viable solution for the escalating costs associated with more costly and risky procedures such as pharmaceuticals, imaging, injections, and surgery.

In fact, declining payment for physical therapy services over the previous 20 years has had the unintended consequence of contributing to the rapid escalation of health care



Physical Therapy
Business Alliance

BOARD OF DIRECTORS

Carl DeRosa, Chair
James Glinn, Jr., Vice-Chair
Jennifer M. Gamboa, Secretary
Michael Weinper, Treasurer
Laurence N. Benz
John Childs
Paul Gaspar
Jeffrey W. Hathaway
Richard W. Shutes

costs for musculoskeletal conditions. This is primarily because the implementation of quality care by a physical therapist earlier in the course of care is more cost-effective by promoting recovery and reducing the need for comparatively more invasive and costly interventions. In other words, there are significant opportunity costs associated with the lack of recognition for the value for physical therapy services within the health care system, primarily the inability of to access lower cost centers within the health care system early on.

This position is supported by a recent article in the *New York Times*³ that highlights the overuse of narcotics in the treatment of workplace injuries, despite the high cost, inherent risks, addictive tendencies, and overwhelming evidence for lack of effectiveness. Further, in our current fee-for-service system, the rate of their use has increased dramatically over the last 20 years as payment rates have increased substantially. Not surprisingly, these increases have come at the expense of payment for more effective and less risky services such as physical therapy. The writer comments that, "In a sense, insurers are experiencing the consequences of their own policies. During the last decade, they readily reimbursed doctors for prescribing painkillers while eliminating payments for treatments that did not rely on drugs, like [physical] therapy."

The Way Forward

Rather than exploring wholesale changes to our current payment system, the current draft of the APTA's APS instead debates how to "fine tune" a fundamentally flawed and dysfunctional system that in the PTBA's opinion is beyond repair. Hamstrung perhaps by Medicare and AMA bureaucracy APTA is working tirelessly on an incremental, long-term approach trying to reason with and add logic to a system within which we have little relevance or influence in the first place. At the end of the day, Medicare policies and reimbursement will not (have not) be driven by clinical science but rather by actuarial science, and the political influence of the special interest groups charged with overseeing the process. Therefore, it is the position of the PTBA that the time for radical payment reform is now.

As a professional association, PTBA is committed to the Triple Aim value of health care reform, which is comprised of 1) measurable quality care, 2) exceptional patient experience, and 3) lower cost of care. At its core, the Triple Aim concept is fundamentally rooted in the concept that payment methodology should be based on a balance of quality and cost. No effective payment system should treat everyone equally and in fact, low quality and high cost quality providers should eventually be eliminated altogether based on a reformed payment model. To address the tenants of the Triple Aim in the payment of physical therapy services, we are proposing an alternative Value-Driven Payment (VDP) model grounded in five key criteria:

1. Simplicity and transparency – What is clear is that a more simple, less regulated system is needed. The current milieu of CPT codes and superimposed rules and regulations adds significant unexplained variation to the provision of physical therapy services and unnecessary monitoring costs for the payer. The delivery of physical



Physical Therapy
Business Alliance

BOARD OF DIRECTORS

- Carl DeRosa , Chair*
- James Glinn, Jr., Vice-Chair*
- Jennifer M. Gamboa , Secretary*
- Michael Weinper , Treasurer*
- Laurence N. Benz*
- John Childs*
- Paul Gaspar*
- Jeffrey W. Hathaway*
- Richard W. Shutes*

therapy services has to be simple and easily managed by both providers and payers, with transparent outcomes and prices.

2. Predictability – Increased predictability for both payers and providers makes it easier to create profitability for both stakeholders while controlling costs. Providers must share some element of risk alongside payers, hence case rating and bundling may be appropriate, assuming payment rates are established in accordance with demonstrated value.

3. Scalability – Any solution has to be implemented on a widespread scale to mitigate risk and make financial sense for all stakeholders.

4. Win-Win/Aligned Incentives – Incentives between providers and payers should be aligned in such a way that the financial results of payers and providers are directly related (ie, as payers do well, so do providers, and vice versa), with the end result of reducing overall costs.

5. Results that exceed expectations – Our current payment system also fails to account for the clinical outcome of the patient. Rather, payers frequently, and mistakenly, proxy quality based on arbitrary utilization threshold, typically assuming that fewer visits is associated with higher quality care. However, this fails to account for the problem of chronicity, primarily that many patients may actually be undertreated in physical therapy and hence more likely to require future healthcare services time due to recurrence. Performance via clinical outcomes must be monitored, with a payment system that rewards clinical excellence and value. Payment incentives should be based on delivering quality care at an affordable price.

Specifically, we propose the establishment of a simple and transparent model in which three timed codes for care rendered by or under the immediate direct supervision of the physical therapist:

Type of code	Time	Payment
I. Brief	Up to 20 minutes	\$60
II. Intermediate	Up to 40 minutes	\$110
III. Full	Up to 60 minutes	\$150

Other aspects of the payment model would include the following:

- Documentation requirements would include specifying the CPT codes associated with each visit to facilitate tracking of treatment patterns at a macro level and determine whether adherent vs. non adherent care according to clinical practice guidelines is being delivered.
- Superimposed rules and regulations (e.g. 8-minute rule, one-on-one, etc.) would be eliminated. The physical therapist would be responsible for the examination, plan, and delivery of care. The use of care extenders would be a clinical decision made by the physical therapist within the scope of his/her state practice act.



Physical Therapy
Business Alliance

BOARD OF DIRECTORS

Carl DeRosa , Chair
James Glinn, Jr., Vice-Chair
Jennifer M. Gamboa , Secretary
Michael Weinper , Treasurer
Laurence N. Benz
John Childs
Paul Gaspar
Jeffrey W. Hathaway
Richard W. Shutes

- Payment per episode would be "capped" by a "hybrid" case based on aggregated data for a given diagnosis and risk adjusted for ten variables per their model for age, acuity, co-morbidities, etc. Stringent criteria for "outlier" exemptions could also be established.
- The need for the Medicare cap would be significantly mitigated or eliminated altogether, which would reduce overly burdensome compliance requirements that add substantial administrative and hidden costs to every clinical encounter.
- The clinical outcomes system can provide PQRS data and patient satisfaction data to complete the last component of the Triple Aim.
- Payment would include outcome-driven incentives such that providers are rewarded for outcomes and efficiency. A model could be constructed according to the follow tiers:

Top 10%	Increase per visit rate during subsequent year, coupled with the same diagnostic-specific cap
25% to 50%	No change
Bottom 25%	5% decrease in per visit rate during subsequent year (Bottom 10% have added constraint of not being eligible for exemptions.)

- A year-end bonus would be awarded based on economic performance and clinical outcomes (change in functional status). For example, this might be done a "withhold" basis in which \$10 per visit is placed in a type of "healthcare escrow" account, with \$5 being reserved from the case rate and an additional \$5 the payer would agree to pay based on performance, which would represent true risk sharing.
- Incentives should be added to encourage primary care providers to refer patients with musculoskeletal conditions (ie, LBP) early to physical therapy. Payers should eliminate referral requirements from their certificates of coverage and work collaboratively with state boards of physical therapy to include unfettered direct access language in physical therapy state practice acts. Such efforts would facilitate patients being able to bypass high cost centers and instead immediately access cost effective providers such as physical therapists. Payers should also consider eliminating or substantially reducing co-pay requirements for cost effective providers such as physical therapists.

Conclusion

The PTBA believes the VDP model is a bold step forward that recognizes the value of physical therapy services in the health care system, while contributing to an overall reduction in downstream health care utilization and costs. Although it is easy to be cynical about the future of health care given the misaligned incentives in the current payment model and many special interest groups, the evidence strongly supports the value of physical therapy services in reducing downstream health care utilization and costs. Our current health care system is in a state of crisis, hence incremental reform such as the model proposed by APTA's APS is simply inadequate to instigate the



Physical Therapy
Business Alliance

BOARD OF DIRECTORS

Carl DeRosa , Chair
James Glinn, Jr., Vice-Chair
Jennifer M. Gamboa , Secretary
Michael Weinper , Treasurer
Laurence N. Benz
John Childs
Paul Gaspar
Jeffrey W. Hathaway
Richard W. Shutes

magnitude of recovery necessary to achieve financial solvency in health care. We are hopeful that CMS will give serious consideration to incorporating this model into Medicare. However, we will in parallel advocate for demonstration projects and definitive payment reform with innovative, value-driven private payers around the country as well. There are significant advantages of taking payment reform to the workers' compensation community, and physical therapy provider networks should adopt the concepts inherent within this proposal today. Quite simply, there are numerous opportunities. We will never get there, or anywhere, without stepping forward. The time is now to do right by the consumer, our patients.

PTBA Board of Directors

References

1. Gellhorn AC, Chan L, Martin B, Friedly J. Management Patterns in Acute Low Back Pain: The Role of Physical Therapy. *Spine*. 2010. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21099735>. Accessed May 29, 2011.
2. Fritz JM, Childs JD, Wainner RS, Flynn TW. Primary Care Referral of Patients with Low Back Pain to Physical Therapy: Impact on Future Healthcare Utilization and Costs. *Spine*. 2012. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22614792>. Accessed June 11, 2012.
3. Meier B. Painkillers Add Costs and Delays to Workplace Injuries. *The New York Times*. 2012. Available at: <http://www.nytimes.com/2012/06/03/health/painkillers-add-costs-and-delays-to-workplace-injuries.html>. Accessed June 11, 2012.
4. Waldman P, Armstrong D. Highest-Paid U.S. Doctors Get Rich With Fusion Surgery Debunked by Studies. *Bloomberg*. Available at: <http://www.bloomberg.com/news/2010-12-30/highest-paid-u-s-doctors-get-rich-with-fusion-surgery-debunked-by-studies.html>. Accessed June 11, 2012.